

JAN 22 1940

MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

4160  
Do not use this space.

1. PLACE OF DEATH  
 (a) County North Registration District No. 2  
 (b) Township Witchell Primary Registration District No. 0  
 (c) City Grant City (d) Street No. \_\_\_\_\_ St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. da. (f) How long in U. S., if of foreign birth? yrs. mos. da.  
 2. PRINT FULL NAME ELVIS SAMUEL CADLE  
 (a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX m 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 20, 1974  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
65 6 21  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Denver Mo.  
 FATHER 13. NAME Charles Cadle  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jackson County Mo.  
 MOTHER 15. MAIDEN NAME Margaret Hillingsworth  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pinneyville Mo.  
 17. INFORMANT (ADDRESS) Clay Cadle Grant City Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Grant City Cem. DATE 1/13 1940  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. C. Truitt Grant City, Mo.  
 20. FILED \_\_\_\_\_ 19 \_\_\_\_\_ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-11 1940  
 22. I HEREBY CERTIFY, That I attended deceased from 1-10 1940, to 1-11 1940.  
 I last saw him alive on 1-11 1940. Death is said to have occurred on the date stated above, at 12:20 AM.  
 The principal cause of death and related causes of importance were as follows:  
Older pneumonia  
 Date of onset 1-5-40  
 Other contributory causes of importance: 10 6  
 Name of operation no Date of \_\_\_\_\_  
 What test confirmed diagnosis? Spinal fluid Was there an autopsy? no  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? no Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place. \_\_\_\_\_  
 Manner of injury no  
 Nature of injury \_\_\_\_\_  
 24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) Clay Cadle M. D.  
 (Address) Grant City, Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed

*Arch C. Dimpfee*

Licensed Embalmer No. *3252*

P. O. Address *Hamlet City, Me*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH  
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CERTIFICATE OF DEATH

4160  
Do not use this space.

1. PLACE OF DEATH

(a) County North Registration District No. 903  
(b) Township Fletcher Primary Registration District No. 6212  
(c) City..... (d) Street No..... St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Elvis Samuel Cadle  
(a) Residence, No. .... St.  (If nonresident, give city or town and State)  
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED S  
(Write the word)

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-11, 1940

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from 19... to 19... Death is said

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

I last saw h. .... alive on ....., 19... Death is said to have occurred on the date stated above, at ..... m. The principal cause of death and related causes of importance were as follows:

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
65- 6 21

Date of onset

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
9. Industry or business in which work was done, as saw mill, bank, etc.  
10. Date deceased last worked at this occupation (month and year)  
11. Total time (years) spent in this occupation

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

FATHER 13. NAME  
14. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME  
16. BIRTHPLACE (CITY OR TOWN)..... (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL  
PLACE ..... DATE ..... 19..

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED Mar. 21, 1940 Clifford Kras Local Registrar.

Name of operation ..... Date of .....  
What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? ..... Date of injury ..... 19...  
Where did injury occur? ..... (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....  
If so, specify P. J. Ross, M. D.  
(Address) Grant City Mo

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

